

**REQUEST FOR DOCUMENTATION**

The person named below has requested accommodations and/or disability-related services at [NAME OF INSTITUTION]. In order to be eligible to use accommodations, the individual must have a documented disability, as defined by federal law.

Disability Support Services will use the information you provide to determine whether this person has a disability and is eligible to use accommodations and/or disability-related services while attending [NAME OF INSTITUTION]. In addition, the functional information you provide will assist Disability Support Services in identifying the appropriate accommodations for this individual.

Person's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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Diagnosis \_\_\_\_\_ Date of Most Recent Evaluation \_\_\_\_\_

Describe the functional impact of the disability on the individual:

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Will the functional limitations described above change over time? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain

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If appropriate, list/describe the treatments, medications, assistive devices, accommodations or services currently prescribed or in use

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Recommendations from professionals who have worked with this person provide valuable information we can use when determining the specific accommodations and/or disability-related services for this individual. Please list any suggestions for accommodations/services you wish to make:

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If your suggestions go beyond what can be appropriately provided at [NAME OF INSTITUTION], we may use your information to suggest referrals to other service providers.

**If student has a learning disability, attach the current psycho-educational evaluation.**

I certify that the information submitted represents this person's **present level of functioning**.

\_\_\_\_\_  
Signature of Professional

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Organization and Address

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_  
Name

SSN: \_\_\_\_\_

\_\_\_\_\_  
Address

DOB: \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code

HEREBY AUTHORIZE:

\_\_\_\_\_  
Name of individual or institution

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

TO RELEASE THE FOLLOWING INFORMATION TO:

University Name  
Disability Support Services (DSS)  
College  
Street Address  
City, State, Zip

Please check all that apply:

<input type="checkbox"/> Medical Reports	<input type="checkbox"/> Medical History	<input type="checkbox"/> Social History
<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Teacher Progress Reports	<input type="checkbox"/> Transcripts
<input type="checkbox"/> IEP/Transition Plan	<input type="checkbox"/> 504 Accommodation Plan	<input type="checkbox"/> Work Evaluation
<input type="checkbox"/> Other: _____		

I understand that I have the right to inspect and to copy any or all of the above information that is to be used to determine appropriate educational and/or supportive services. This authorization is limited to that information specified above. I understand that I have the right to revoke this authorization at any time by submitting a written request and that my refusal to consent to the release of these records will prevent disclosure to the individual/institution named above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date